EvidenceNOW
Advancing Heart Health in Primary Care

Northwest Cooperative

HEALTHY HEARTS NORTHWEST
An EvidenceNOW Project

EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW establishes seven regional cooperatives composed of public and private health partnerships that provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the **ABCS** of cardiovascular disease prevention: **A**spirin in high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Cooperative Name:
Healthy Hearts Northwest: Improving Practice Together

www.healthyheartsnw.org

Principal Investigator:
Michael L. Parchman, M.D., M.P.H., Group Health Research Institute

Cooperative Partners:
MacColl Center for Health Care Innovation and the Center for Community Health Evaluation, both at Group Health Research Institute

Qualis Health

Oregon Rural Practice-based Research Network (ORPRN) at Oregon Health & Science University

Institute of Translational Health Sciences at University of Washington

Geographic Area:
Washington, Oregon, Idaho

Project Period:
2015-2018

Region and Population

The Pacific Northwest consists of urban centers, rural agricultural communities, Native American reservations, and sparsely populated counties. The region has a growing urban and rural Hispanic population, as well as rapid overall population growth in the urban cores. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer resources than in urban areas. Heart attack deaths in the small rural counties are almost twice as high as in larger metropolitan counties (e.g., the heart attack death rate in Washington's rural Adams County is 275 per 100,000 and is 121 per 100,000 in urban King County).[1] The death rate from stroke is higher in the Pacific Northwest than in the United States as a whole.

Specific Aims

1. Identify, recruit, and conduct baseline assessments in 250-320 small- to medium-sized primary care practices across Washington, Oregon, and Idaho during the project's first year.
2. Provide comprehensive practice support to build quality improvement (QI) capacity within these practices.
3. Disseminate and support the adoption of patient-centered outcomes research (PCOR) findings relevant to aspirin use, blood pressure and cholesterol control, and smoking cessation (ABCS) quality measures.
4. Conduct a rigorous evaluation of strategies that enhance the effectiveness of external practice support to improve QI capacity, implement PCOR findings, and improve ABCS measures.
5. Assess the sustainability of changes made in QI capacity and ABCS improvements and develop a model of scale-up and spread for improving QI capacity in primary care practices.

Reach

- Goal for Number of Primary Care Professionals Reached: 750-960
- Goal for Population Reached: 1.13-1.44 million

AHRQ Agency for Healthcare Research and Quality
NATIONAL CENTER FOR EXCELLENCE IN PRIMARY CARE RESEARCH

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UPDATES ON KEY PROJECT COMPONENTS

Support Strategy

Each participating practice will receive 15 months of support from practice facilitators in two key areas:

- *Health information technology support and use of data for Physician Quality Reporting System (PQRS) reporting and QI*. The cooperative will help the practices improve PQRS reporting of ABCS measures by creating a tailored Action Plan to guide the support. Practices will have varying experience with PQRS reporting and need different levels of information technology support. Practice facilitators will support practices in person and through ongoing phone and secure Internet communication to help with electronic health record (EHR) data extraction.
- *External practice QI support*. This support will enhance the practices' capacity to use new PCOR findings to change their care practices and improve ABCS measures. To build their QI capacity to adopt and implement PCOR heart health findings, practices will be assessed and then receive tailored external support through practice facilitation (i.e., a kick-off meeting, face-to-face visits, regular phone calls) and shared learning opportunities (i.e., Webinars and office hours led by content experts and practice facilitators). Practice facilitators administer the Quality Improvement Change Assessment (QICA), a tool developed by the cooperative to determine a practice's need for practice improvement assistance. Facilitators review the tool with the practice team at the initial welcome visit and again around the fourth in-person visit, which will occur around the 12th month.

The study will compare the effectiveness of two enhanced practice support activities in addition to practice facilitation:

- *Shared learning opportunities through site visits*. Practices that are randomized to this enhanced practice support activity will visit an innovative primary care practice. They will observe and interact with team members from other primary care practices that also attend the site visit.
- *Peer-led educational outreach (academic detailing)*. Practices that are randomized to the educational outreach intervention will learn about team-based implementation of a cardiovascular disease risk calculator. The activity includes an online video followed by a one-on-one phone call between a clinical team and a physician academic expert, and a conference call with other practices participating in this activity.

Practices will be randomized to one of four intervention arms of the study using a two-by-two factorial design: practice facilitation only, practice facilitation plus shared learning, practice facilitation plus educational outreach, or practice facilitation plus both shared learning and educational outreach.

Update

- Practice facilitators frequently have been helping practices with data extraction issues. For example, a clinic may have an EHR but no staff person to pull the necessary data. Depending on the practices' interests and experience, the practice facilitators are also coaching them on clinical guidelines, team-based care, care coordination, patient activation, and other high leverage changes that are part of the Northwest cooperative's QI change package.
- The details of the two enhanced practice support activities are under development. These two intervention arms will be implemented between September and December 2016.

Evaluation

Staff member surveys and practice surveys will be administered at three points in time. ABCS data will be collected quarterly over the study period. The cooperative will assess changes in State context and also study which strategies enhance the improvement of QI capacity and the adoption of PCOR.

Update

- The cooperative is providing modest compensation to practices for their data collection activities to help meet a goal of 100 percent response rate for the practice survey and a goal of 75 percent response rate for the staff survey.
- The cooperative is also collecting ABCS data by surveys. They are continuing to collect 2015 one-year "look-back" data and 2016 ABCS data from the first quarter; they are slightly more than one-quarter completed. As reporting ability improves, practices can retrospectively get a complete data set.
- The cooperative developed a protocol for data quality checks.
- Practices receive an online dashboard to compare their ABCS measure to their State, region, and nationally. Additionally, this dashboard shares Million Hearts® and EvidenceNOW goals.
- Practices receive summary graphs of their practice and staff survey results to compare to other practices in the cooperative.

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Strategies for Disseminating Study Findings and Lessons Learned:

Update

- The cooperative regularly tweets, sends e-blasts to practices, writes stories in pertinent blogs and newsletters (e.g., Oregon Rural Practice-based Research Network's newsletter, Qualis' newsletter, medical society newsletters), and posts best practice guidelines, tools, and lessons learned on their Web site.
- The cooperative also plans to disseminate findings in manuscripts, white papers, and policy briefs, and through local and national presentations at conferences and forums.

SPOTLIGHT ON RECRUITMENT

Comment from Principal Investigator

Michael Parchman, M.D., M.P.H.

"The number of competing practice improvement initiatives across the three States has been confusing to smaller primary care practices. In addition, many of them are facing extraordinary competing demands from acquisitions, re-alignments, and increased reporting requirements. I find it remarkable that we have been able to engage with practices in this challenging environment."

Recruitment Specifics

The cooperative is currently completing recruitment efforts with the aim of successfully enrolling 250 clinics. To date, it has 217 enrolled practices—104 active in Oregon, 96 active in Washington, and 17 active in Idaho—and has assigned practice facilitators to 211 practices. Among the recruited practices are four Indian Health Service (IHS) tribal clinics in Oregon and six IHS tribal clinics in Washington.

The cooperative's original goal was to complete enrollment by the end of April 2016. However, they extended enrollment to June 1, 2016, to provide more opportunity to recruit the target 250 practices. Many practices have expressed interest but have not officially signed up, so this additional recruitment window may allow those practices to commit.

Factors that Contributed to Recruitment Success

- **Leveraged existing relationships:** Overall, recruitment success is attributed to existing relationships with providers or health care systems. These relationships were of significant help in recruiting practices within the large health systems in Washington and Oregon.
- **Outreach to tribal practices:** The cooperative successfully recruited several tribal clinics in Washington and Oregon. This was a population they had hoped to engage in EvidenceNOW.
- **Alignment with national initiatives:** Many practices are preparing for upcoming payment reform, so communicating how EvidenceNOW could help practices become ready to gather and extract quality improvement data was key.

Challenges to Recruitment and How the Cooperative Responded

- **Changes in the nature of primary care practices:** Many practices have become part of large organizations, resulting in fewer small practices available for recruitment. This required additional leveraging of existing relationships and digging deeper to find eligible practices.
- **Competing quality improvement initiatives and changing payment reform:** At least five competing initiatives are active in the EvidenceNOW Northwest region. Practices feel overwhelmed and do not know which to join. A carefully honed message about the benefits of participating in EvidenceNOW and its alignment with these initiatives and quality payment programs, like the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models, was often persuasive.
- **Limited response to general outreach efforts:** Many practices did not respond to a general outreach approach. The cooperative continues to explore ways to recruit these practices successfully.

[1] *Kanarek N, Bialek R, Stanley J. Use of peer groupings to assess county public health status. Prev Chronic Dis 2008 Oct;5(3):A139.*

Last updated date: May 26, 2016